

Integrated Health Home Workgroup Meeting June 22, 2022

June 22, 2022

Role Call

Format of Workgroup

- Discuss prior meeting (high level)
- Topic for the meeting
- Plan and expectations for next meeting

It is ok to ask questions during the meeting and between meetings. These questions and answers will be shared at the beginning of each meeting.

What is Our Why? What Do We Want to Accomplish?

- Identify how the Health Homes meet the provider standards set forth by the federal government as well as identify appropriate oversight of those standards.
- Develop a proposal for a payment methodology that is consistent with the goals of efficiency, economy, and quality of care. The rate will be developed according to the actual cost of providing each component of the service.
- Review member qualifications in order to propose qualifications that meets federal and state code.
- Update Health Home Services to reflect whole-person team based-care while reducing provider burden.
- Develop a Quality Improvement model that can be adopted by Integrated Health Homes.
- Develop a proposal to present to the State that encompasses all the forementioned goals.

Ground Rules

- You can respect another person's point of view without agreeing with them.
- Respectfully challenge the idea, not the person and bring potential solutions.
- Blame or judgment will get you further from a solution, not closer.
- Honest and constructive discussions are necessary to get the best results.
- Listen respectfully, without interrupting.
- Listen actively and with an ear to understanding others' views. (Don't just think about what you are going to say while someone else is talking.)
- Commit to learning, not debating. Comment in order to share information, not to persuade.
- Avoid blame, speculation, and inflammatory language.
- Allow everyone the chance to speak.


Objectives

- Review of Last Meeting and Workgroup Report
- Health Home Services
 - Include discussion of who can do what and examples of documentation.
 - Include HIT requirements for specific services.
 - Function and roles
 - Hab/CMH vs Health Home Requirements need clarified

Last Meeting

- Discussed Payment Methodologies, Member Qualifications, Provider Qualifications.

Workgroup Report

<p> Department of HUMAN SERVICES</p> <p>Integrated Health Home Program Proposed Changes Report</p> <p>Executive Summary</p> <p>In February 2022, the Iowa Medicaid convened a stakeholder workgroup to review the Integrated Health Home Program. The goals of the workgroup include:</p> <ul style="list-style-type: none">Identify how the Health Homes meet the provider standards set forth by the federal government as well as identify appropriate oversight of final standards.Develop a proposal for a payment methodology that is consistent with the goals of efficiency, economy, and quality of care. The rate will be developed according to the actual cost of providing each component of the services.Review member qualifications in order to propose qualifications that meet federal and state code.Update Health Home Services to reflect whole-person team based-care while reducing provider burden.Develop a Quality Improvement model that can be adopted by Integrated Health Homes.Develop a proposal to present to the State that encompasses all the aforementioned goals. <p>Health Homes are to coordinate care for people with Medicaid who have chronic conditions. The Centers for Medicare & Medicaid Services (CMS) expects states health home provision to operate under a "whole-person" philosophy. Health Home providers will integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to treat the whole person.</p> <p>The Integrated Health Home Program currently serves approximately 19,000 Medicaid enrollees with around 12,500 adults and 6,500 kids. The Integrated Health Home Program currently Care Managed members that are in habilitation (about 6,500) or Children's Mental Health Waiver (about 1,000).</p> <p>In conclusion, the Workgroup recommends the implementation of XXXXXXX.</p> <p>1320 E. Walnut Street, Des Moines, IA 50319-0110</p>	<p>Setting the Stage</p> <p>The workgroup spent time reviewing federal guidance, the Current SPA as well as need what changed from the 2016 SPA. The group also spent time reviewing Iowa Administrative Rules that open for comment. The group discussed information that might be helpful for them to review to assist in developing improvements to the SPA. There were suggestions for process review as well the identification for areas that will need to be determined during a deeper dive into the requirements. These were added to the plan for future documents and will be incorporated into next steps if they do not require an update to the SPA.</p> <p>Review of the Health Home Survey, site visit, and listening sessions identified lots of potential process improvement needs. The group identified that information around payment will be useful when discussing payment model design. With the change in requirements to be applicable Case Management, the payment model should mirror that.</p> <p>Diving into the Details</p> <p>Health Home Provider Standards</p> <ul style="list-style-type: none">The SPA page 9 states Integrated Health Home (IHH) will include, but not limited to meeting the following criteria: "Clearly by adding 'new' meeting one of the following criteria"Be an Iowa accredited Community Mental Health Center or Mental Health Services Provider or an Iowa licensed residential group care setting.Iowa Licensed Psychiatric Medical Institution for Children (PMIC) facility.Nationally accredited by the Council on Accreditation (COA).The Joint Commission, or Commission on Accreditation of Rehabilitation Facilities (CARF) under the accreditation standards that apply to mental health rehabilitative services.Remove "Child" and "Adult" from nurse on page 16 of the SPA.Further research on "Complete status reports to document member's housing, legal, employment status, education, custody, etc." so the group can discuss further recommendations. Plan to follow-up.The group recommends the SPA language change from "nurses" in the statement: "Work with LE or IME to receive members redirected from emergency Department, engage in planning transitions in care with area hospitals, and to follow-up on hospital discharges, including Psychiatric Medical Institutions for Children (PMIC) to accept." <p>2</p>	<ul style="list-style-type: none">Work with LE or IME to accept members redirected from emergency Department, engage in planning transitions in care with area hospitals, and to follow-up on hospital discharges, including Psychiatric Medical Institutions for Children (PMIC).The group recommends removing "approved by the state" in the 2022 SPA on page 18 "Have evidence of bi-directional and integrated primary care/behavioral health services through use of a contract, memoranda of agreement or other written agreements approved by the State."SPA Page 19, the group recommends making Participate in ongoing process improvement on clinical indicators and overall cost effectiveness specified by and reported to the State two bullets.Participate in ongoing process improvement on clinical indicators and overall cost effectiveness specified by and reported by to the State and Lead Entity.Participate in ongoing process improvement on clinical indicators overall cost effectiveness within the Health Home. Notes April 13, 2022 Page 9The group would like the bullet on page 20 "Complete web-based member enrollment, assessment, member consent to release information, and health risk questionnaires for all members" to be moved under Coordinated Care.The group would like "evaluate" to be clarified on page 18 of the SPA "Monitor, manage, and evaluate appropriate evidence-based and evidence-informed preventive services" to change to evaluation or assessment of services.Health Information Technology<ul style="list-style-type: none">The group asks for support for implementing an EHR that includes funding and technical assistance.The group asks for time to be built into the SPA to allow for implementation. This would be a three-year process.The group recommends using the language from WV "As the use of HIT and the implementation of a statewide health information exchange evolves, it is anticipated that the use of HIT to support all of the health home services will also evolve."The group agrees that a patient registry is important but to not require it be tied to the EHR.The group does not recommend adding requirements around Habilitation and Children's Mental Health Waiver to the Standards. <p>3</p>
<p>Lead Entity Standards</p> <ul style="list-style-type: none">Two bullets "Assessment of the Integrated Health Home and medical health provider's capacity to coordinate integrated care" and "Provide infrastructure and tools to Integrated Health Home providers and primary care physical providers for coordination" read aligned. Suggest:<ul style="list-style-type: none">Assessment of the Integrated Health Home and primary care provider's capacity to coordinate integrated careProvide infrastructure and tools to Integrated Health Home providers and primary care providers for coordination.In the State Plan amendment "Provide oversight, training, and technical support for Integrated Health Home providers to coordinate integrated care" should be one bullet. <p>Payment Methodologies</p> <ul style="list-style-type: none">Consider using a code other than 99606. IHCs looking at codes to propose, will send call to all IHH directors once those codes have been identified.Consider changes to the informational codes Waiting on a Survey from Health Homes.<ul style="list-style-type: none">Only requiring 1Removing the requirement all together as the 99606 is allowing to providing a Health Home Service.Change the tier to High, Medium, Low using a risk tool. Potentially 1 or a crosswalk to ensure apples-to-apples across individual risk tools. <p>Member Qualifications</p> <ul style="list-style-type: none">Review the list of qualifying diagnoses from the 2016 SPA<ul style="list-style-type: none">SPH<ul style="list-style-type: none">Psychotic DisordersSchizophreniaSevere/Infective DisorderMajor DepressionBipolar DisorderDelusional DisorderObsessive Compulsive DisorderBroaden the definition for what provider type can provide the diagnosis (i.e., CMHC) <p>4</p>	<ul style="list-style-type: none">Allow the functional impairment tool to be completed by the IHH (group will remove CARF and Non-ICM assessment) <p>Team Qualifications</p> <ul style="list-style-type: none">Nurse Care Manager<ul style="list-style-type: none">Add UPI as an optional additional role to support the RN, BSN. (Group is asking this back to their organizations)Care Coordinator<ul style="list-style-type: none">May have a BSW degree in another field with 3 years of experience.Allow for an exception to policy for asbyme need.Must follow Chapter 46 Requirements for Care Coordinator when the member has habilitation under CMH Waiver.Peer Support and Family Peer Support<ul style="list-style-type: none">Update to reflect the University of Iowa training for Peer Support and Family Peer Support <p>Health Home Services</p> <ul style="list-style-type: none">Updating comprehensive care management, page 40 related to HIT. Worked a little difficult. Streamline the verbiage. Each service has HIT is not that the LE was providing to help with the care service. Page 39 and 40 and how the state will provide HIT. Then 4 bullets of what the Health Home is, and then would different in CCM. <p>Comprehensive Care Management</p> <ul style="list-style-type: none">Whole person comprehensive care management. CMS rules indicate oversight of the assessment or just the PCP? Does the assessment need to have direct oversight of the team?Page 39 wrap around planning process development and implementation of strength-based individualized person-centered care plans addressing the needs of the whole child and family, why is that separated out? Care plan encompasses this, is there another reason why it is written that way? Call out child. <p>Care Coordination</p> <p>Health Promotion</p> <p>Individual and Family Support</p> <p>Referral to Community and Social Support</p> <p>Quality Improvement</p> <p>Conclusion and Next Steps</p> <p>5</p>	<p>Process Improvement Recommendations</p> <ul style="list-style-type: none">Simplify documentation <p>6</p>

Follow-up

Workgroup Report Page 2

- Further research on “Complete status reports to document member's housing, legal, employment status, education, custody, etc.” so the group can discuss formal recommendations.
 - After reviewing with LeAnn, this needs to remain. We can add this to the process parking lot.


Workgroup Report Page 3

- Review Update

Workgroup Report Page 4 and 5

- Review additions from last meeting
 - CASH/Non-ICM assessment identify FI?
 - Other tools for FI?
 - LPN as an optional additional role to the RN, BSN

Overview of the Timeline



Health Home Quality Improvement Workgroup

The Health Home Quality Workgroup is tasked with the development of learning topics and activities.

This workgroup will meet bi-weekly from 9am to 11am. Proposal will be submitted to IME for review. The plan is to update the SPA based on approved recommended changes.

Date	Topic IME
February 1, 2022	Level Setting <ul style="list-style-type: none"> Federal Requirements OTC Final Report/State's response
February 16, 2022	Level Setting <ul style="list-style-type: none"> Integrated Health Home SPA <ul style="list-style-type: none"> What are we meeting now? What changes were made and why? (Added, Edited, or deleted) Include SPA from 2016 as supporting documentation.
March 3, 2022	Finish Reviewing the IHH SPA (Starting with Health Promotion) <ul style="list-style-type: none"> What are we meeting now? What changes were made and why? (Added, Edited, or deleted) Flow chart of what is the authority (Federal code, Iowa code, SPA...) Include SPA from 2016 as supporting documentation. Iowa Administrative Rule (draft)
March 16, 2022	Review of Last meeting's feedback Review of the site feedback, survey, and Listening Sessions. Health Home Providers
March 20 th , 2022	Review of Last meeting's feedback Health Home Providers Provider Standards <ul style="list-style-type: none"> How does the Health Home Meet? Peer Support and Family Peer Support IHH responsibility to coordinate services when they qualify for Habilitation/CHW, but services are not available. Managing Habilitation and CMHW How does the MCO/Iowa Medicaid support and oversee? Address feedback of MCO/IME Administrative Oversight Burden

April 12, 2022	<ul style="list-style-type: none"> Using the larger organization to support the work Review of Last meeting's feedback Provider Standards <ul style="list-style-type: none"> Peer Support and Family Peer Support IHH responsibility to coordinate services when they qualify for Habilitation/CHW, but services are not available. Managing Habilitation and CMHW How does the MCO/Iowa Medicaid support and oversee? Address feedback of MCO/IME Administrative Oversight Burden Using the larger organization to support the work
April 27, 2022	Review of Last meeting's feedback Provider Standards <ul style="list-style-type: none"> IHT CMH/Habilitation Methodologies <ul style="list-style-type: none"> Health Home Services documentation on the claim.
May 11, 2022	Methodologies <ul style="list-style-type: none"> Health Home Services documentation on the claim. Member Qualifications <ul style="list-style-type: none"> MCO/IME Support of Provider Enrollment Activities How does CMH and Habilitation fit into this?
May 25, 2022	Review of Last meeting's feedback Member Qualifications <ul style="list-style-type: none"> Address the LMHP requirement for FI (propose recommendations) <ul style="list-style-type: none"> Multiple ask for records, incomplete records, refusing to share records. Causes an access to Health Home Services barrier Health Home doesn't want to turn away eligible members Causing provider alienation between LMHP and IHH Creates bottleneck Team Qualifications <ul style="list-style-type: none"> Name: looking at recent Rule, what is allowed? Peer Training: (age requirement, additional training, support needs of the IHH) Care Coordinator: Other Rule, ETP allowances.
June 8, 2022	Review of Last meeting's feedback Health Home Services Include discussion of who can do what. Also,

	examples of documentation. Include IHT requirements for specific services. Function and roles. <ul style="list-style-type: none"> Comprehensive Case Management Care Coordination Health Promotion Comprehensive Transitional Care Individual and Family Support Referral to Community and Social Support Services <ul style="list-style-type: none"> Definition Health Information Technology Benefits/Service can be provided by... Description (Who can do what under this IHHS)
June 22, 2022	Review of Last meeting's feedback Quality Improvement <ul style="list-style-type: none"> Learning Collaborative contents Newsletter IHH Internal QI/QA structure
July 6, 2022	Review of Last meeting's feedback Quality Improvement IHH Internal QI/QA structure
July 20, 2022	Putting it all together. Presentation of Draft Proposal and SPA

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Documents for Today



Table of Contents

State/Territory Name: IA

State Plan Amendment (SPA) #: 16-0013

This file contains the following documents in

- 1) Approval Letter
- 2) Summary Form (with 179-like data)
- 3) Approved SPA Pages

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Health Home Services

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care from Inpatient to Other Settings (Including appropriate follow-up)
- Individual and Family Support (which includes authorized representatives)
- Referral to Community and Social Support Services

Brainstorming Document

Next Steps

- Continue Health Home Services
 - Include discussion of who can do what.
 - Include HIT requirements for specific services.
 - Function and roles
 - Hab/CMH vs Health Home Requirements need clarified